Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	: **RAMI SAMIR KAMAL ABDELAZIZ**	**Service Date**	**:16-Jan-2024**	**Network**	: Green
Card No	: **I017-029-116591803-02**	**Health Provider**	**:Irham Medical Center Arjan**		**Direct Access SP - YES**
Policy Holder	: **RAMI SAMIR KAMAL ABDELAZIZ**	**Doctor's Name**	**:Sajid Sanaullah**		
Payer Name	: **ABU DHABI NATIONAL INSURANCE COMPANY-ADNIC**	**Co-Insurance**	:		
TPA	: **E CARE - Green Network**	**Remarks**	:		
Validity	: **01-01-1900** To **30-09-2024**				
Gender	: **Male**				
Date Of Birth	: **22-Jan-1985**				
Patient's Tel No	: **971566442706**				

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : C/O PAIN IN TEETH SINCE LAST NIGHT,ASSOCIATED WITH FEVER ON EXAMINATION PATIENT HAD DECAYED TOOTH **Duration:**

Vitals: Temp : 36.5 Bp :120 Pulse :78 Resp :22

Clinical Findings:

Diagnosis: K04.7 - Periapical abscess without sinus,K08.89 - Other specified disorders of teeth and supporting structures, **Date of Onset** :16/14/2024

Estimated Cost :

Requested Investigations: 9, Consultation GP

Prescriptions: 0005-107903-1171 - (IBUPROFEN : 600 MG) TABLETS,0139-116207-1171 - (CLAVULANIC ACID : 125 MG) (AMOXICILLIN : 500 MG) TABLETS,0067-116604-0391 - (METRONIDAZOLE : 500 MG) FILM COATED TABLETS, **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

PATIENT'S DECLARATION :

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Dr's Name : Sajid Sanaullah **Stamp :**

Patient 's signature{Parent : if minor}

Date : 16-Jan-2024

Signature :

Date : 16-Jan-2024